ALBERTA HEALTH SERVICES

Health Plan
and
Business Plan
2013-2016

Better Quality, Better Outcomes, Better Value

Alberta Health Services

Statement of Accountability

This three-year health plan for the period commencing April 1, 2013 was prepared under the Board's direction in accordance with the Regional Health Authorities Act and direction provided by the Minister of Health.

The strategic direction and priorities of Alberta Health Services have been developed in the context of legislated responsibilities, the Alberta Health business plan, and provincial government expectations as communicated by the Minister.

Performance measures are included as the basis for assessing achievements.

The Board and administration of Alberta Health Services are committed to achieving the planned results laid out in this three-year health plan.

Respectfully submitted on behalf of Alberta Health Services,

"Original Signed"

Stephen H. Lockwood, QC

Chair, Alberta Health Services Board

Message from the President and Chief Executive Officer

Better Quality, Better Outcomes, Better Value. This is the "triple aim approach" that will move Alberta Health Services through the next three years. We are focused on how we can improve your experience with the health system and the quality of care we provide, how we can work with Albertans to improve your health and how we can get more value from the money and resources we invest.

Our goal is to become a leading health system, with some guiding principles in mind:

- we are working to simplify the health system by looking at care delivery through the eyes of Albertans and their families,
- we are attempting to make the system more efficient through local and site-based decision-making and reducing bureaucracy, and
- most importantly, we are working to ensure that Albertans are getting the right care, in the right place, at the right time no matter where they live in Alberta.

We know we are making progress. There is better access to important services, wait times are coming down and we are adding capacity in key areas.

We are going to change how we work together as health care teams, across the system, to ensure that no matter where you access care, your experience is at the centre of everything we do. We want it to be easy for you to know where to go for the help you need. We will work to reduce our focus on hospital-based care and instead concentrate our efforts on community-based and primary health care services, so we can provide the most appropriate care for you, closer to home.

Many Albertans are dealing with complex, chronic diseases and as our population ages, these numbers will increase. We want to work as partners in wellness, supporting those with diabetes, heart conditions, addiction and other health challenges to better manage your health and access the services you need. We each must play a role in our own health – getting healthier and staying healthier will also improve the health of our system.

We are going to continue to be very thoughtful about where we invest health care dollars because this has a direct impact on what we can do to improve the health of Albertans.

We recognize there's a lot of work ahead.

This Health Plan and Business Plan are based on what health care services Albertans have told us are important to them. It's about the needs of Albertans right now and the challenges we face with a growing population and a tighter financial future. These plans are designed to take us from here, in 2013, to where we need to be, in 2016 and beyond.

The path ahead will have challenges, but we will work with Albertans, our staff, physicians, volunteers and Government to build a sustainable quality health system for all Albertans and their families.

Sincerely,

Dr. Chris Eagle

President and CEO, Alberta Health Services

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1. Alberta Health Services Health Plan and Business Plan 2013-2016

The Alberta Health Services Health Plan and Business Plan 2013-2016 presents the overall direction of the organization and highlights significant actions that will be undertaken over the next few years as the organization meets its responsibilities under the Regional Health Authorities Act. See Appendix I. This plan is submitted to the Minister of Health as a proposal and is built upon a solid foundation of achievements to date.

Capacity has been added in the province and we have reduced wait times for key procedures.

1.1 What Have We Achieved?

Since 2008, the skilled and dedicated health professionals, support staff, volunteers and physicians of Alberta Health Services have been working to promote wellness and provide health care every day to approximately 3.8 million Albertans, as well as to many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories.

We have built a health care foundation in this province that will provide Albertans with better access to high-quality care and reduce wait times for surgeries, cancer treatment and continuing care. We have been working to create a patient-focused health system where decisions are made closest to where care is provided.

Making progress

- We are starting to reap the rewards of the time, effort and money invested by Alberta Health Services in improving our province's health system and we can celebrate some important achievements.
- We have partnered in expanding new primary care models, including 40 Primary Care Networks, three Family Care Clinics and seven Urgent Care Centres, to give Albertans more direct access to health care services.
- We are working to implement the Alberta government strategy to create a more seamless system for addictions and mental health.
- We have opened close to 3000 new continuing care spaces since 2010, as part of a strategy to increase access and care choices for seniors.
- Capacity has been added in the province with the opening of the South Health Campus in the Calgary Zone and the Kaye Edmonton Clinic in the Edmonton Zone - improving patient care and access to out-patient services.

- We have cut wait times for key procedures – reduced the wait time for elective Coronary Artery Bypass Graft procedures by 27 days, hip replacements by 10 days, knee replacements by 43 days and cataract surgeries by 79 days, since 2010.
- We started posting "real time" Emergency Department wait times by urban hospitals in Calgary and Edmonton. The first in Canada to do so.
- We introduced public reporting of medical procedure wait times by physician and hospital, as published on the Alberta Wait Times Reporting Website.
- We have provided improved access to stroke care resulting in 23 per cent fewer emergency/hospital visits and over 25 per cent fewer in-hospital deaths from stroke.

1.2 Where Are We Now?

With only four years behind Alberta Health Services, we have already taken great strides down the path to better health care in this province. Despite this great start we have farther to go and more to accomplish.

A Snapshot

Life expectancy has gone up in Alberta: Albertans born in 2011 are expected to live to 81.7 years of age; that's up from the 79.6 years expected for Albertans born in 2000.

Over the last 10 years, Alberta's teen birth rate has decreased, and, in that same time period, the birth rate for Albertan women between the ages of 35 and 44 has increased. Unfortunately, in 2011, 6.7 per cent of infants were born at a low birth weight, 8.2 per cent of infants were born preterm, and, between 2009 and 2011, the smoking rate amongst pregnant women in Alberta was more than 15 per cent.

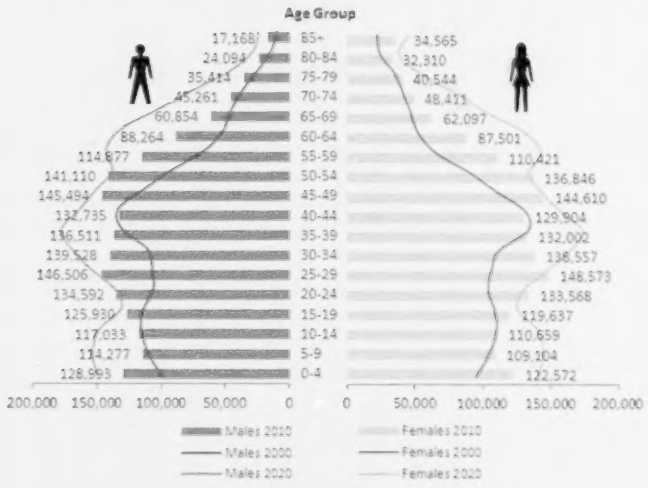
In 2011, more babies were born to women living in the Calgary Zone compared to the rest of the Province; the fewest number of babies are born to women living in the South Zone.

From 2009 to 2011, the top two causes of deaths in Alberta were circulatory disease and cancer. Together, these two causes accounted for approximately 60 per cent of all Albertan deaths.

In 2011, 21 per cent of Albertans aged 12 and over reported being current smokers, 21 per cent reported being heavy drinkers, and 44 per cent were considered inactive. In that same year, 33 per cent of Albertans were overweight, 20 per cent of Albertans were obese, and 25 per cent reported high levels of stress. Obesity, smoking, physical inactivity and stress are risk factors associated with cancer, circulatory and other chronic diseases.

The North Zone had the highest rate of obesity in the province at 29.8 per cent, compared to a low of 16.3 per cent in Calgary Zone

From 2002 to 2012, Alberta's population has grown at twice the rate of the rest of Canada.



The majority of Alberta's population growth has occurred in the major urban centres of Edmonton and Calgary.

Alberta has one of the youngest populations in Canada with the North Zone having the lowest average age across all zones (34.3 years), more than two years younger than the Alberta average of 36.6 yrs.

Our average family income is $98,240.

It is projected that by 2031, one in five Albertans will be a senior, or over the age of 65.

Challenges on the Road Ahead

Like many areas in Canada and beyond, Alberta's health care system is facing challenges in the months and years ahead. We need a health care system that can respond to the changing needs of the population while maintaining quality care that is fiscally responsible and sustainable.

In spite of Alberta's high per capita expenditure, some of our health outcomes are lower than the Canadian average.

Alberta's population is going to continue growing.

Over the past 10 years, Alberta's population has grown at a compound annual growth rate of 2.2 per cent (compared to 1.1 per cent in Canada), adding about 745,381 persons. In other words, we've added the equivalent of eight cities the size of Red Deer in that time. While our population has grown 2.2 per cent, our emergency department visits in 2011/12 increased by 4.5 per cent since 2010/11 and urgent care visits have increased by over 10 per cent from 2010/11 to 2011/12. More people in the province mean more demand on our health care resources.

Alberta's population is aging.

As we age, we depend more on the health care system. It is projected that by 2031, one in five Albertans will be a senior. Already, approximately 30 per cent of Albertans report having at least one chronic health condition and that number increases to over 75 per cent if you are 65 years of age or older.

Currently, Alberta's publicly funded health system spends over $1 billion a year on continuing care. This includes health services provided at home, in supportive living accommodation and in long-term facilities for individuals who can no longer live at home. With the growing population of older Albertans and an anticipated increase in chronic disease and dementia, meeting these needs is going to require significant effort and integration of policies and services by government, health service providers, researchers and others.

We need to better understand the health care requirements of our population.

We know a substantial number of Albertans may not be receiving the health care they need in the right place. Many of these individuals have complex, often chronic conditions, yet they may not have ready access to the services they need to help them to take an active role in their health. Their needs are often met through hospital settings when their care could be managed better in other health care settings. It is important Alberta Health Services better understand the needs of these groups in order to anticipate and provide appropriate care in their communities, to support improved health and quality of life.

We need to address costs and achieve better health outcomes for the money we spend.

Alberta's health spending growth rate of 10.4 per cent (from 2000 to 2010) exceeds the Canadian average of seven per cent. Despite having the second highest age-adjusted spending per person in Canada, our health outcomes are not significantly better than the Canadian average and in some areas are worse.

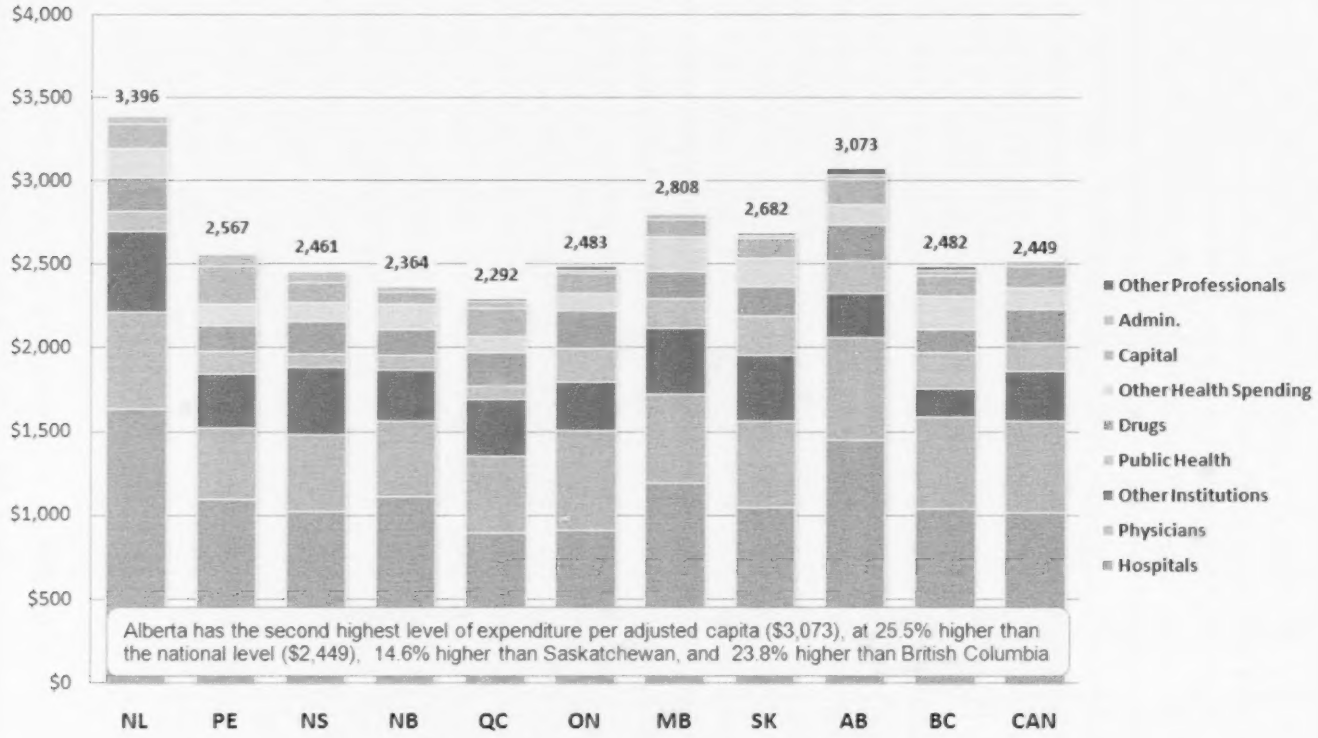
A number of factors contribute to the cost of delivering health care in the province.

- Health workforce compensation, for example, accounts for a large portion (38%) of what the government spent on health care in 2010/11. Alberta's health workforce is better compensated, on average, than other places in Canada.
- While Alberta compares relatively favourably to other jurisdictions on a number of productivity measures, gains in productivity are still needed. Productivity refers to the amount and quality of services we deliver in relation to the time, staff and materials needed to deliver those services.
- The use and cost of pharmaceuticals accounts for a significant amount of Alberta's health care spending. In 2010/11 our average spending on drugs was 6.1 per cent more than the national average and the third highest in the country.
- In recent years the use of laboratory and diagnostic imaging services has increased by six per cent annually, with a 3 per cent annual increase in cost. It is anticipated that sophisticated new technologies and increasing numbers of screening procedures could become a major driver of costs if not evaluated and used appropriately.

It is clear we must address a variety of challenges if we are to achieve a truly sustainable, quality health system now and into the future. In addition, Alberta, like other Canadian jurisdictions, is facing the need to reduce health care spending in response to the current world economic situation and fiscal pressures while still delivering vital services for Albertans across the province.

Expenditure per Adjusted Capita, for 2012[1,2]

Province, Adjusted by Age and Gender and Presented by Constant 1997 Dollars



Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2012 (Ottawa, Ont.:CIHI, 2012)
2010 adjustment factors by age and gender and based total healthcare expenditure were applied to 2012 population data

Province	Hospitals	Other Institutions	Physicians	Other Professionals	Drugs	Capital	Public Health	Admin.	Other Health Spending	2012 Total
Newfoundland	1,627.79	486.95	580.57	14.87	201.71	142.77	115.63	47.22	178.85	3,396.36
Prince Edward Island	1,088.30	326.83	426.15	10.23	150.29	218.62	137.37	76.83	132.62	2,567.25
Nova Scotia	1,014.66	402.10	465.42	8.30	200.98	125.57	73.64	62.25	107.88	2,460.80
New Brunswick	1,102.96	310.00	450.79	5.15	149.47	73.54	90.82	27.96	152.96	2,363.65
Quebec	892.13	335.73	457.84	16.50	204.53	165.46	77.68	42.31	99.58	2,291.76
Ontario	901.99	296.15	595.43	19.92	224.60	117.66	202.25	22.87	102.02	2,482.87
Manitoba	1,187.02	392.61	530.15	14.76	158.76	105.99	178.83	30.04	210.27	2,808.44
Saskatchewan	1,045.78	397.64	508.05	14.46	178.37	122.50	230.28	13.37	171.17	2,681.63
Alberta	1,444.83	270.98	609.25	40.72	220.63	149.97	188.02	25.49	123.04	3,072.94
British Columbia	1,033.17	162.66	551.20	23.57	140.39	123.47	219.93	27.92	199.49	2,481.80
Canada	1,013.11	298.98	545.12	20.71	200.60	133.41	166.37	30.75	126.36	2,448.83

1.3 Where Are We Going?

Alberta Health Services can't achieve significant change in the health system on its own. Lasting health care change will only be possible if we work as partners with Albertans, all levels of government, businesses and communities to create a health system that meets the needs of Albertans. We need to focus our efforts to achieve real transformation and build a system that will meet our current and future needs.

Focus on Our Mission: To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

We cannot afford to wait for change to evolve, we need to be proactive and take action throughout the health care system.

We know we need to make changes in how we deliver safe, quality health care:

- We need to develop new service models, build a strong community and primary health care foundation, reduce reliance on acute care hospitals and focus on patient-centred coordination and seamless movement through the system.
- We also need to optimize everyone's contribution within the province's health workforce.
- We must engage Albertans as part of the health system and invest in health promotion. We must work to keep people healthier by encouraging and supporting Albertans to play an active role in their own health and that of their families.
- We need to better use evidence when we make decisions, design and deliver services, consider best possible outcomes for our patients and figure out how to invest our money wisely.

- We need to engage staff, physicians, volunteers and our Health Advisory Councils in developing innovative approaches to health service delivery and work together to focus on better quality, outcomes and value.

We have significant challenges ahead which must be addressed to achieve a truly sustainable, quality health care system now and for the future. We also have many opportunities to improve the health care of Albertans and our health care system.

Deliver Better Quality, Better Outcomes, Better Value

Working together, Alberta Health and Alberta Health Services will take a "triple aim" approach in improving health care: improving patient experience and quality of care, improving health outcomes and improving value for money. These high order dimensions informed our strategic directions listed below.

Strategic Direction – Bringing Appropriate Care to Community

Goal 1: Build a strong integrated community and primary health care foundation to deliver appropriate, accessible and seamless care.

Strategic Direction – Partnering for Better Health Outcomes

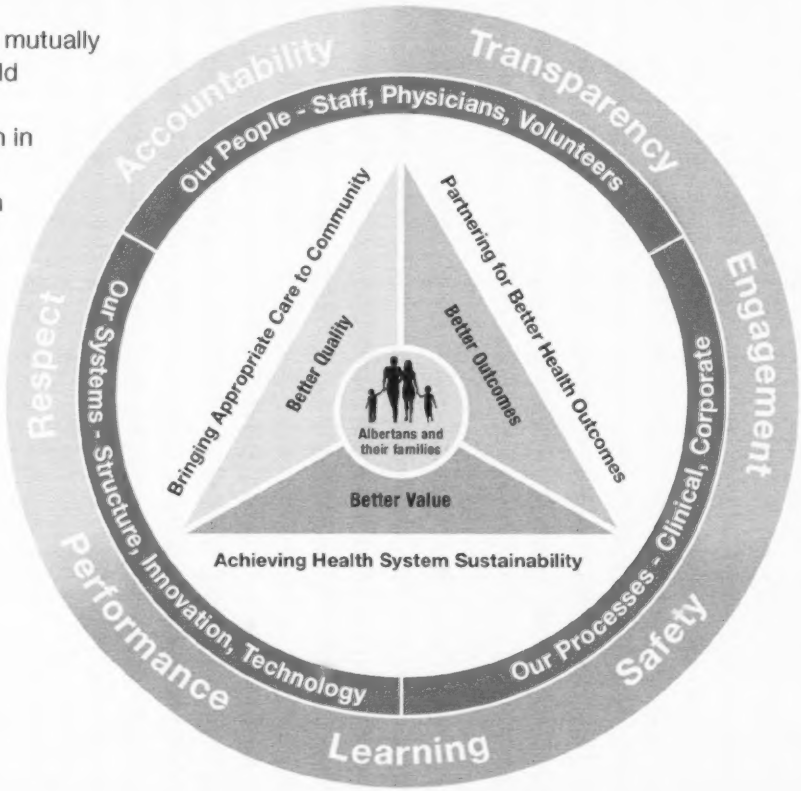
Goal 2: Actively engage Albertans as partners and provide them with the support they need to take responsibility for their health and that of their families.

Goal 3: Advance the adoption of evidence-informed practices in the delivery of quality services across the continuum through partnerships with providers, academic institutions, physicians and others.

Strategic Direction – Achieving Health System Sustainability

Goal 4: Continue to build a sustainable, quality health system that is patient centered, driven by outcomes and informed by evidence.

These strategic directions and goals are not mutually exclusive. Actions in one area can and should support or complement actions in another. Significant initiatives and actions undertaken in support of the directions and objectives will span the short, medium and longer terms. In addition, high level and other performance measures, developed in collaboration with Alberta Health, will help us determine progress in each of our strategic directions.



Our Values and Strategic Directions

Our work is grounded in our values. Our values guide the decisions we make in relation to our strategic directions and associated actions.

2. The Path Forward – Our Plan for Action for the Next Three Years

2.1 Bringing Appropriate Care to Community

Objectives:

- Strengthen integration and collaboration across community-based services and primary health care providers by developing appropriate service delivery models and inter-professional care teams to: address the specific health needs of individual Albertans and their families, help them navigate the system and improve patient experience.
- Develop continuing care spaces, service options and/or capacity to respond to our changing demographics and to provide quality care and support to Albertans and their families and caregivers.
- Deliver innovative service delivery models to address the complex, high needs populations.

Albertans and their families will experience a more coordinate and seamless approach to service delivery.

In order to achieve our objectives, we will begin in 2013/14 by:

Strengthening community and primary health care

Primary health care is the first point of contact a person has with the health system – the point where people receive care for most of their everyday health needs. Alberta Health Services supports all Albertans having access to a primary health care team and a range of health care and social service providers no matter where they enter the system. Alberta Health Services will work with Alberta Health in increasing the number of family care clinics and enhancing the services provided by primary care networks. This means we will carefully assess the need for any growth in acute care spaces, ensure these resources are used most effectively, and focus our efforts on providing appropriate services in community settings.

Working across Ministries

Alberta Health Services will continue to work with partners in Health, Education and Human Services to deliver greater coordination and integration in support of the Early Childhood Development strategy. As well, Alberta Health Services will continue to increase and improve its linkages and working relationships across Ministries including Alberta Justice and Solicitor General to support specific populations.

Developing innovative service models

Alberta Health Services is redesigning how we can deliver care more appropriately to specific complex, high needs populations. We are developing an integrated primary health care service model, which will focus on linking many existing services to provide support to identified population groups. We are also developing collaborative team care models, for both urban and rural services, for populations with similar needs. Those groups will include the frail elderly, the vulnerable, complex high-needs children and youth, and those at the end of life. This work will be phased in across the province with family care clinics in Edmonton and Calgary as the first to change their focus of care. We will also develop specific ways to reach, support or provide treatment for all Albertans with a significant chronic disease such as diabetes, congestive heart failure, chronic obstructive pulmonary disease and mental health challenges.

Increasing service integration and accountability

Having regular and timely access to a primary health care team is one of the best ways we can provide effective health care services in Alberta's communities. To make sure our services are more connected at the local community level, Alberta Health Services will increase coordination and collaboration between all health service providers including primary, community (such as emergency medical services, continuing care, addiction and mental health), home and acute care, starting with communities that have family care clinics. Alberta Health Services will identify a number of groupings of health services and health providers (operating units) that will work together and be accountable for the quality, safety, access and costs associated with an identified population. By working together, health care providers, services and programs can focus on improving health outcomes for Albertans, optimizing the use of our resources and reducing duplicate or unnecessary administrative processes. We will develop a set of accountability measures for these operating units to ensure we are focused on outcomes that deliver better quality and experience, better health results and better value for Albertans.

Implementing the continuing care plan and the addiction and mental health strategy

To make sure we are providing the right care, at the right time, in the right place, Alberta Health Services will continue to work with Alberta Health to execute the Continuing Care Plan. Work will continue on expanding the provincial discharge initiative that includes a standard approach to discharge planning in hospital settings with a focus on enabling patients to be discharged home as an alternative to discharge to facility-based care. In addition, the provision of home care services will be streamlined and services will be standardized. The provincial Addiction and Mental Health Strategy will be supported through the development of innovative community-based service models to address individuals with complex addiction and mental health needs and the further development of coordinated and consistent access for children and adolescents to addiction and mental health services.

Our Performance Measures

Progress on achieving change in Alberta's health system will be monitored and reported through a number of system outcome measures. These system level measures drive Alberta Health Services' strategic accountability measures as noted below.

STRATEGIC DIRECTION	ALBERTA HEALTH SERVICES, OUR STRATEGIC PERFORMANCE MEASURES (ACCOUNTABILITY)
Bringing Appropriate Care to Community	Per cent of family members satisfied with long term care
	Per cent satisfied with acute care
	Per cent complex or high needs population attached to primary health home (preliminary focus on AHS health homes)
	Congestive heart failure and chronic obstructive pulmonary disease patients discharged from acute care with a primary care/appropriate specialist visit within 30 days
	Per cent of 30-day unplanned readmits for cardiac patients (primary diagnosis)
	Per cent of 30-day unplanned readmission rate for mental health patients (primary diagnosis)
	Per cent 30 day unplanned surgical readmission rate

2.2 Partnering for Better Health Outcomes

Objectives:

- Engage Albertans as partners in health and in achieving better health outcomes for themselves and for their families.
- Improve wellness, health promotion, and injury and disease prevention programs as part of the Alberta Health Services continuum of services and deliver these services in a manner that considers health equity. This means that we will deliver services in a way that takes into account each person's current health needs and situation.
- Engage academic researchers, Alberta Innovates Health Solutions, government ministries and communities, as partners in improving health outcomes and in providing Albertans with the information and other supports they need to understand, make decisions and manage their health.
- Deliver programs and services based on best available research, evidence and practice standards and monitor, evaluate and update these programs and services based on health outcomes achieved and share the knowledge we gain from our experience.

Access to appropriate care at the appropriate place will be improved and variation in care across the province will be reduced.

In order to achieve our objectives, we will begin in 2013/14 by:

Prevention and early detection

Immunization is often cited as one of the most important medical success stories. Since the introduction of vaccines, rates of diseases for measles, mumps, rubella, polio and diphtheria have declined dramatically. Alberta Health Services' annual seasonal influenza immunization program contributes to individual and population level influenza prevention, including prevention of outbreaks in our facilities. Alberta Health Services will also continue to lead the delivery of childhood immunization programs for a variety of communicable diseases as well as cervical cancer prevention.

In addition to prevention efforts aimed at keeping people healthy, Alberta Health Services is also working to identify those with chronic diseases early, before their disease progresses, to help limit the long-term effects their disease may have on their health. Examples of this include, implementing the Rural Stroke Action Plan and the Vascular Risk Reduction Project. A further example is Alberta Health Services' cancer screening programs, which target prevention and early detection of breast, cervical and colorectal cancers. These organized screening programs strengthen the quality of screening processes at every step in the screening pathway, reduce harms associated with over-screening and contribute to a reduction in cancer mortality. We will also continue our efforts in support of environmental public health, including inspections of restaurants, swimming pools and residential housing.

Partners in health

Alberta Health Services is working with Alberta Health to implement a long-term plan to promote wellness. However, the health system alone cannot make people healthier. We must partner with Albertans, other government departments, health service providers, communities, businesses and others to support individuals in taking personal responsibility for their health and Albertans in turn need to understand how to manage their own health and that of their families.

In order to be successful, service providers need to understand the health needs of Albertans and their communities. For example, Alberta Health Services is continuing its work with the Health Advisory Councils to better understand the needs of Albertans and their communities. Alberta Health Services is also working with the Aboriginal Wisdom Council to support a collective understanding and better response to the needs of First Nations, Métis and Inuit people.

Significant work is underway to enhance access for all Albertans to health information and advice through MyHealthAlberta and Health Link Alberta. In addition, patient safety is an important ongoing focus. It is imperative that the voice of Albertans be embedded into the valuable work done every day to enhance and maintain the quality of all care within Alberta Health Services. Quality, including a focus on patient safety, is a critical area where the patient voice is vital. The staff, physicians and volunteers of Alberta Health Services are also key partners in health and their voices will help us build a system that makes best use of their talents and improves the quality, outcomes and value of our health system.

Strategic Clinical Networks

Strategic Clinical Networks (SCN) and Operational Clinical Networks (OCN) are engines of innovation, bringing together physicians, clinicians, patients, researchers, staff and partners across Alberta to develop strategies, which are based on evidence, to improve patient outcomes and satisfaction. The SCNs and OCNs will also improve access to health care and the long-term sustainability of the health care system. SCNs and OCNs will focus on:

- Building provincial programs with consistent processes to improve the connections between clinical teams and the quality of care that is provided. They support disease prevention and early intervention in the progress of a disease, while they work to improve transitions of patients between levels and locations of health care service, and advance the teamwork between primary, community, home and acute care health providers. This work includes: standardizing and automating referrals and wait time management for key procedures such as cancer care and hip and knee replacements and developing standardized benchmarks for all surgeries at all surgical sites in Alberta.

- Building equity of care across the province, so that the same level of quality is available no matter where you are in Alberta. This work includes: centralized provincial intake for hip and knee arthroplasty and implementation of full continuum of support (prevention through post surgery) for hip fractures.

- Accelerating the implementation of evidence-informed practices and standards across the full range of services offered throughout the province. This work includes: integration of nutrition care and physical function practices to enhance recovery from surgery, province wide implementation of the safe surgery checklist, development of standards for the use of insulin pump therapy, and best practice guidelines for the appropriate use of antipsychotics in long term care settings. In addition, there is ongoing assessment of how well we are doing in improving access to services and ensuring services are used in the right way and at the right time.

Model of care transformation

Alberta Health Services will continue work on the model of care transformation underway as we move to a collaborative practice model. Simply put the care transformation and collaborative practice model ensures that all staff are working together and to the full scope of their roles. This increases the amount of time that is spent directly caring for our patients and brings the patient and their families into the care planning process and early discharge discussions.

Clinical information systems

A common clinical information system, which will help clinicians to have up-to-date information on patients, test results and procedures, will be designed and implemented for the province beginning in the Edmonton Zone. This system will serve as a platform to: support implementation of care pathways, standardize best practice, reduce duplication, provide decision support to manage patient flow and allow patients and providers to collaborate quickly, securely and with real-time, trusted information across the province. This is an important step forward in ensuring each Albertan has a single, up-to-date, accessible health record that supports the provision and continuity of care and ultimately improves the performance of the health system. In addition, we will use our information systems to provide clinical outcome information to help us improve our services and provide physicians with information that will assist them in decision making and better serving their patients.

Health technology assessment

We review and assess our health technologies (our medical devices and processes, excluding drugs) on an ongoing basis to determine what we need to replace or change and when that needs to happen. This assessment process will be enhanced and expanded to include a more rigorous approach to new and existing technologies to ensure they are appropriately supporting the required outcomes. To this end, Alberta Health Services works collaboratively and in alignment with the Alberta Health Technology Decision process through the Alberta Advisory Committee on Health Technologies (AACHT), jointly chaired by Alberta Health and Alberta Health Services. The AACHT addresses which health care technologies should be publicly funded. Health technology assessment reviews will be directed toward unmet high priority heath care needs of Albertans as well as the unmet capacity to deliver both effective and sustainable health care. Strategic Clinical Networks (SCN) and Operational Clinical Networks (OCN) are an important source of identifying unmet health needs and delivery requirements. In addition health research and innovation needs of Albertans, identified through the SCNs and OCNs will be a primary source for supporting a joint Alberta Health Services and Alberta Innovates Health Solutions research and innovation agenda.

Cancer strategy

Alberta Health Services will work with Alberta Health to implement the new provincial cancer strategy. This strategy is focused on accelerating the implementation of evidence-informed clinical pathways (how patients optimally flow through the system), best practices and standards in cancer surgery (beginning with lung cancer); prevention and early detection through screening; support for cancer survivors and provision of palliative care.

Our Performance Measures

Progress on achieving change in Alberta's health system will be monitored and reported through a number of system outcome measures. These system level measures drive the development of Alberta Health Services' strategic accountability measures and targets, which will be available later in 2013/14.

STRATEGIC DIRECTION	ALBERTA HEALTH SERVICES, OUR STRATEGIC PERFORMANCE MEASURES (ACCOUNTABILITY)
Partnering for Better Health Outcomes	Five day in-hospital mortality following major surgery
	Per cent of patients diagnosed at early stage (e.g. stage 1 and 2) for most common cancers
	Medical oncology access-referral to first consult with medical oncologist (90th percentile in weeks)
	Radiation therapy access (referral to first consultation) (90th percentile in weeks)
	Hip replacement surgery wait time ready to treat to treat (90th percentile in weeks)
	Per cent of paediatric surgeries performed within wait time window (PCATS wait time methodology)
	Age-standardized hip fracture event rare (per 100,000 population) by acute and continuing care
	MRSA (Methicillin Resistant Staphylococcus Aureus) blood stream infection rate
	Hospital acquired C-difficile infection rate

2.3 Achieving Health System Sustainability

Objectives:

- Invest health care resources to achieve optimum value now and in the future.
- Improve the efficiency and productivity of our workforce and services.
- Increase our focus on improving the quality of care we provide and the equity of health outcomes achieved for the money we invest.

Alberta Health Services will focus on opportunities to achieve innovation and transformation for better quality, better outcomes and better value for Albertans now and in the future.

In order to achieve our objectives, we will begin in 2013/14 by:

Scheduling and rotation management

Through improved scheduling and rotation management, Alberta Health Services will increase the number of staff that work full- time in the province and use best practice standards to determine how we can best use the staff resources that we have. Consistency in scheduling and opportunities for full- time employment will support and improve continuity of care for our patients.

Innovation, productivity and efficiency in acute care service delivery

As part of planning at the local level, a consistent province-wide approach will focus on efficiency and productivity improvements in acute (hospital) care and ultimately in every health care setting. Protocols to support emergency medical services personnel in treating patients and avoiding hospitalization will continue to be implemented. In addition, for surgeries and procedures not requiring hospitalization, non-hospital settings will be used, providing Albertans with better access to the care they need and ensuring our hospitals are available for those who need them. The productivity of our workforce will be supported through ongoing initiatives to improve workplace health and safety.

Medication management

Alberta Health Services is committed to supporting the health of those in our care by making sure the medications selected in treatment are those that provide the best therapeutic value. Improving the quality of our formulary and medication use will include: established drug-use protocols, identifying appropriate therapeutic interchange and addressing medication administration delays.

Aligning needs and service models

The population and health needs of Alberta communities are changing. Some Alberta Health Services' programs and service delivery models are no longer meeting the needs of their communities. Changes in population needs, use of services and how we deliver health care will be considered when we are planning at the system, zone, and community level. How we deliver services and the appropriate setting for those services must be aligned with the needs of individuals within their communities and the surrounding areas. For example, some individuals could be better served through a change from an acute care focus to an integrated community and primary health care focus. This will also provide the opportunity for the implementation of chronic disease management or other care models that can appropriately address the needs of local residents. Alberta Health Services will work with communities in designing appropriate services for their area including looking at better ways to deliver services.

Measuring outcomes

In collaboration with Alberta Health, Alberta Health Services will develop and implement an outcomes based measurement framework to standardize measurement and reporting of our progress in improving the health care experience of Albertans, improving health outcomes and achieving value for resources invested. The high level measures from this framework are included in this Health Plan and Business Plan.

Funding models

Alberta Health Services will develop models and allocate funding for programs and service providers across the continuum of care based on the care needs of the patient and/or the needs of the population group.

Our Performance Measures

Progress on achieving change in Alberta's health system will be monitored and reported through a number of system outcome measures. These system level measures drive the development of Alberta Health Services' strategic accountability measures and targets, which will be available later in 2013/14.

STRATEGIC DIRECTION	ALBERTA HEALTH SERVICES, OUR STRATEGIC PERFORMANCE MEASURES (ACCOUNTABILITY)
Achieving Health System Sustainability	Day case surgery rate for high volume procedures amenable to outpatient service
	Average length of stay/expected length of stay ratio in acute care facilities
	Head count to full time equivalent (FTE) ratio
	Per cent of patients placed into continuing care within 30 days
	Peer cent alternate level of care (ALC) patient days
	Ratio of primary care, ambulatory care expenditures to acute care expenditures
	Overtime hours to paid hours ratio (AHS employees)
	Disabling injury rate (AHS workforce): claims resulting in lost and/or modified work

3. Conclusion

This Health Plan and Business Plan represents the beginning of significant transformation in the health system in Alberta.

This is not a journey we can complete in the next year or the year after, and it is not a journey we can undertake alone. Alberta Health Services will work with government, Albertans, communities, organizations and our staff, physicians and volunteers to build on past successes, take advantage of the opportunities before us and deliver better quality, better outcomes and better value. Key to success will be our partnership with Albertans to support them in getting healthier and staying healthier. We all have a role to play in our own health and in that of the health system we depend upon.

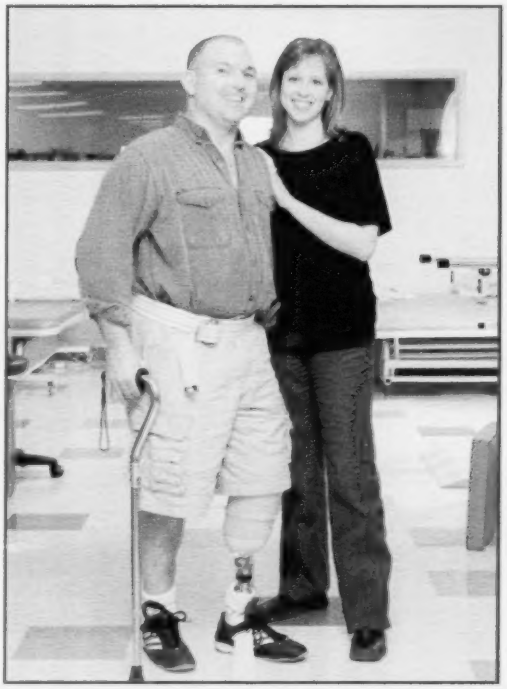
While we cannot make the changes required all at once, we can begin with decisive action in the short-term. We will be acting on our strategic directions and goals through a number of initiatives that fall into seven key work streams. These are:

- **Delivering innovative service models for complex high needs populations** – The frail elderly, the vulnerable, complex high needs children and youth and those at the end of life are four example populations that require more proactive, community based services. These services will be delivered in fundamentally different ways to improve their quality of life by reducing frequent visits to the emergency department and subsequent inpatient stays.
- **Strengthening community and primary health care to deliver care in the most appropriate setting** – We will support all Albertans being attached to a primary health care team no matter where they enter the system. Alberta Health Services will support Alberta Health in increasing the number of family care clinics and enhancing primary care networks. Albertans and their families will experience a more coordinated and seamless approach to service delivery at the local and system level, including wellness and prevention and greater follow-up after they are in hospital.
- **Advancing the adoption of evidence-informed practices and clinical appropriateness** – We will focus on building truly provincial programs with consistent processes to improve clinical integration and quality, support prevention and early intervention, improve transitions between levels and locations of service, and advance the integration between primary, community, home, long-term and acute care. We will also focus on accelerating the implementation of evidence-informed processes and standards across the continuum of care and throughout the province. This will include reassessing current practices, technologies and access to the system to make the best use of our continuum of services.
- **Implementing new funding models and revenue initiatives** – We will allocate funds to programs and service providers based on the needs of the patients and populations served. We will also improve our processes for interprovincial billings and standardize our Emergency Medical Services billing rates.

- **Optimizing service delivery** – There are opportunities for Albertans in a number of communities to be served better through a change in the nature of the services available. In some communities, for example, this may mean a change from an acute care focus to a community and primary health care focus. We will work with communities to determine how best to meet their service needs.
- **Driving productivity improvements** – We can and must improve the productivity of our workforce through adopting care models that make the best use of the skills of our physicians and staff, providing greater opportunities for full time work for our nurses and continuing to improve our processes, procedures and flow of patients through our system.
- **Containing costs** – We are taking steps to contain or reduce the costs associated with delivering health care services in Alberta. All areas will be examined, including supplier contracts, compensation and benefits.

We will also improve our ability to understand and anticipate the needs of our growing and changing population and our ability to adjust our services accordingly. We will ask Albertans, our Health Advisory Councils, our staff and physicians and volunteers to provide input and share ideas on how we can simplify the health system and streamline the patient journey, while providing high-quality patient care more effectively and efficiently. And, we are going to invest wisely where our health care dollars will provide the best value and have the most impact on improving the health of Albertans.

The opportunities before us are many, however, we need to be nimble and be willing to work together in new ways to achieve better quality and patient experience, better health outcomes and better value for money.



Appendix I – Alberta Health Services Responsibilities under the Regional Health Authorities Act

Consistent with the Regional Health Authorities Act the Alberta Health Services Health Plan and Business Plan 2013–2016 outlines how the organization intends to fulfill its mandate over the next three years and includes the 2013/2014 operating budget. The Health Plan presents key initiatives under each of the three Strategic Directions for the organization. Some high level examples of these initiatives are presented below for illustrative purposes by Regional Health Authorities (RHA) Act areas of responsibility.

RHA RESPONSIBILITIES	STRATEGIC DIRECTION			ALBERTA HEALTH SERVICES (AHS) INITIATIVES
	Bringing Appropriate Care to Community	Partnering for Better Health Outcomes	Achieving Health System Sustainability	
Assess, on an ongoing basis, the health needs of Albertans.	X	X	X	Alberta Health Services (AHS) zones will develop long-term sustainability plans based on geographic and population needs assessments.
Determine priorities in the provision of health services in Alberta and allocate resources accordingly.	X	X	X	AHS and Alberta Health have jointly developed strategic directions for the health system in Alberta which inform the identification of priorities in each area including: allocation of funds to programs and service providers based on the needs of the patients and populations served and improvement of processes for interprovincial billings and standardize of Emergency Medical Services billing rates. AHS is also taking steps to contain or reduce the costs associated with delivering health care services in Alberta. All areas will be examined, including supplier contracts, compensation and benefits.
Ensure reasonable access to quality health services is provided in and through Alberta Health Services.	X	X	X	AHS will support Alberta Health in increasing the number of family care clinics and enhancing primary care networks. This includes the development and implementation of integrated primary health care service models to better meet the needs of individuals and communities. A more coordinated and seamless approach to service delivery at the local and system level will be developed and will include wellness and prevention and greater follow-up after Albertans leave hospital. Innovative service models will be developed to address complex, high needs populations such as the frail elderly, the vulnerable, complex high needs children and youth and those at the end of life. More proactive, community based services will be delivered in different ways to improve quality of life by reducing frequent visits to the emergency department and subsequent inpatient stays. AHS will continue to work with Alberta Health to implement the Continuing Care Plan and the Addiction and Mental Health Strategy. The provincial discharge planning initiative will be expanded and home care will be streamlined and services standardized.

RHA RESPONSIBILITIES	STRATEGIC DIRECTION			ALBERTA HEALTH SERVICES (AHS) INITIATIVES
Promote and protect the health of the population of Alberta and work toward the prevention of disease and injury.	X	X	X	AHS will collaborate with Alberta Health in the development of a provincial Wellness Strategy to improve overall population wellness. AHS will work with Albertans and others as partners in helping individuals take responsibility for their own health. This includes providing health information and advice through MyHealthAlberta and Health Link Alberta. Prevention and early detection will include immunization, screening for cervical, breast and colorectal cancer and implementation of the Rural Stroke Action Plan and the Vascular Risk Reduction project. Through Strategic and Operational Clinical Networks, AHS will support evidence-informed services including prevention and early intervention programs, improve quality and clinical integration and transitions between levels and locations of service. AHS will also focus on accelerating the implementation of evidence-informed processes and standards across the continuum of care and throughout the province. This will include reassessing current practices, technologies and access to the system to make the best use of our continuum of services. The development of a provincial clinical information system will further contribute to supporting better care for Albertans.
Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta.	X	X	X	Aligning needs, service models and facilities is key to providing appropriate services in appropriate settings for Albertans. A number of communities can be served better through a change in the nature of the services available. AHS will work with communities to determine how best to meet their service needs. Improvements in the productivity of our workforce will be supported through adopting care models that make the best use of the skills of our physicians and staff, providing greater opportunities for full time work for our nurses and continuing to improve our processes, procedures and flow of patients through our system.

Appendix II – 2013/14 Budget and Multi-Year Outlook

Introduction

The 2013/14 Budget and Multi-Year Outlook outlines the commitment of Alberta Health Services (AHS) to allocate financial resources to meet strategic and operational priorities for health care services including:

- Bringing Appropriate Care to Community;
- Partnering for Better Health Outcomes; and
- Achieving Health System Sustainability.

This summary fulfills AHS's commitment to the Board of Directors (the Board) and to Alberta Health (AH) and provides a public document that describes AHS's commitment to Albertans.

Figure 1: 2013/14 Budget Compared to 2012/13 Budget

(in millions)	2012/13 Budget	2013/14 Budget	Difference	% Change
Base operating grant from AH[1]	10,212	10,521	309	3.0
Other revenue	2,517	2,834	317	12.6
Total Revenue	12,729	13,355	626	4.9
Total Expenses	12,737	13,355	618	4.9
Operating Surplus (Deficit)	(8)	-	8	100.0

Context for Financial Planning

Government Funding

AHS will receive a 3 percent increase in the operating grant from AH in 2013/14. It is also expected that AHS will receive a 3 percent increase in 2014/15 and a 2 percent increase in 2015/16. These rates of increase are lower than historical increases for health care spending in Alberta.

The operating grant from AH represents over 25 percent of government's operating budget and as such, it is AHS's responsibility to be part of the solution as government faces significant economic and fiscal challenges. AHS must live within its means and continue to foster financial sustainability.

[1] In 2012/13, $2 million was added to the base operating grant after AHS's budget was approved by the Board resulting in actual funding of $10.214 million. In 2013/14, AH is increasing the base funding by $307 million above the 2012/13 payment.

Growth in Demand

For most of the last decade, the rate of increase in health care spending in Alberta has been close to 10 percent per year. Although the rate of increase has slowed recently, spending has continued to grow as a result of:

- Population growth, aging and morbidity;
- Increases in utilization of services; and
- Unit cost increases, including compensation increases and inflation.

A review of comparative information across Canada indicates that Alberta has the second highest adjusted health care expenditure per capita, along with relatively higher utilization of selected health care services and higher costs per unit of service.

Health System Sustainability

Planning for health care sustainability must consider the key drivers of health care costs and ensure these are managed to limit the rate of spending increase and promote sustainability and value for money in the future.

In the short-term, AHS will undertake initiatives to manage unit costs, achieve operational efficiencies and productivity improvements, optimize service delivery and implement new funding models and revenue opportunities to manage costs and deliver on AHS's strategic directions.

AHS will also continue to work to ensure long-term sustainability. Focused efforts that guide system transformation and foster long-term sustainability are needed in areas such as:

- Delivering innovative service models for complex, high needs populations;
- Strengthening community and primary health care to deliver care in the most appropriate setting; and
- Advancing the adoption of evidence-informed practices and clinical appropriateness.

AHS has made significant efforts in 2012/13 to position itself as stable and financially sound in 2013/14. AHS expects to finish the 2012/13 fiscal year with a balanced operating position. This is positive, however, it also points to the need for continued financial discipline as one-time savings (e.g., vacancies, delayed initiatives) have contributed to AHS's ability to address demand growth and still achieve a balanced position in 2012/13.

Guiding Principles

AHS has established the following guiding principles for sustainability planning:

Patient Care:

- Act thoughtfully with safe, quality patient care and health outcomes at the forefront of decisions;
- Maintain access to services as key priority across the continuum of health – from prevention to end of life;
- Create a sustainable health system by aligning investments to strategic directions.

Our Staff / Physicians and Volunteers:

- Treat all staff, physicians and volunteers in accordance with our values;
- Build leadership capacity to support local decision making and increase accountability for integrated service delivery across the continuum at the community level;
- Continue to engage front-line staff and leaders – looking for efficiency and less bureaucracy – place more decision making in the hands of those closest to the patient;
- Support staff, physicians and volunteers to identify and act on opportunities to enhance quality, clinical appropriateness, safety and effectiveness.

Overall:

- Live within our means - maintain a balanced annual operating position;
- Adopt a strong Focus and Finish - disciplined approach to prioritizing and creating capacity to complete initiatives;
- Work with Alberta Health to promote a single health care system.

2013/14 Budget

The 2013/14 Budget describes AHS's expected financial position on a consolidated basis and includes the following:

- Three wholly-owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta;
- 50% interest in the 40 Primary Care Network (PCN) partnerships with physician groups;
- 100% of 26 controlled foundations; and
- Provincial Health Authorities of Alberta Liability and Property and Insurance Plan.

Revenues

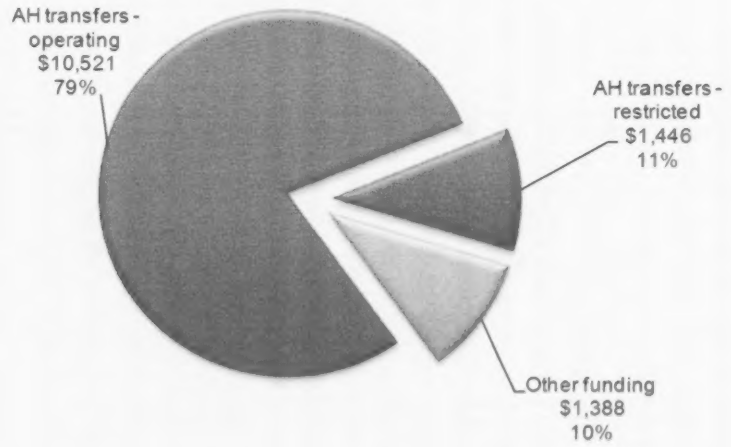
In 2013/14, total revenues will be $13,355 million, an increase of 4.9 percent, or $626 million.

AHS operating revenues primarily consist of the base operating transfer and restricted transfers from AH. The base operating transfer from AH will be $10,521 million, an increase of 3 percent or $309 million over the 2012/13 budget. AH restricted transfers will be $1,446 million, an increase of 24.2 percent or $282 million. AH restricted transfers include $393 million (an increase of $126 million over the 2012/13 budget) for South Health Campus and Kaye Edmonton Clinic[2].

Other revenues include federal and provincial (excluding AH) government contributions, investments, donations from foundations, trusts and individuals as well as revenue from ancillary operations such as parking, non-patient food services and sale of goods and services. Other revenues will be $1,388 million, an increase of 2.6 percent or $35 million, primarily due to increases to other government transfers and fees and charges.

[2]The 2012/13 forecast for South Health Campus and Kaye Edmonton Clinic is $185 million. In 2013/14, AH will provide an additional $208 million above the 2012/13 forecast.

Figure 2: 2013/14 Revenue Sources as a Percentage of Total Revenue



Expenses

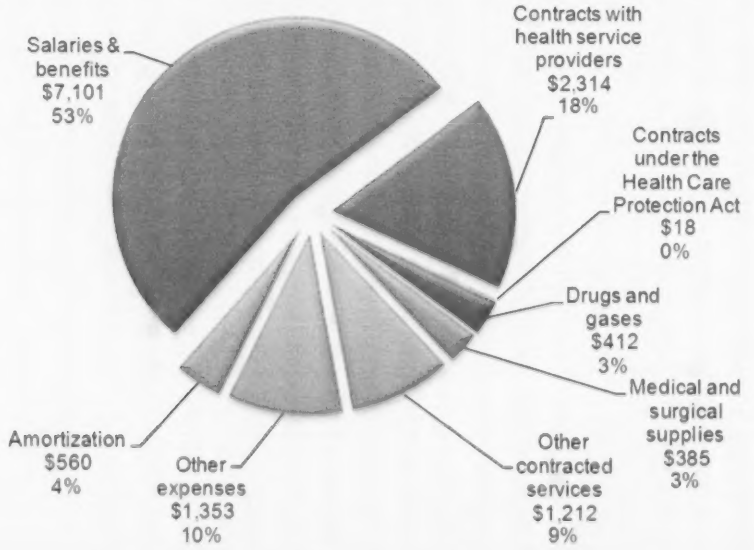
In 2013/14, expenses will equal $13,355 million, an increase of 4.9 percent, or $618 million. This represents an average daily spend of $37 million to support the health system in Alberta.

Expenses by Object

Salaries and benefits represent the largest expense at $7,101 million or 53 percent of total expenses. Physician fees and purchased services are reported under other contracted services. The majority of physician fees are funded directly by AH.

Contracts with health service providers make up the second largest expense at $2,314 million or 18 percent of total expenses. All other expenses, including supplies, drugs and gases, other contracts, and amortization total $3,940 million or 29 percent of total expenses.

Figure 2: 2013/14 Revenue Sources as a Percentage of Total Revenue


Salaries & benefits $7,101 53%
Contracts with health service providers $2,314 18%
Contracts under the Health Care Protection Act $18 0%
Drugs and gases $412 3%
Medical and surgical supplies $385 3%
Other contracted services $1,212 9%
Other expenses $1,353 10%
Amortization $560 4%

Expenses by Financial Directive

AHS reports its costs by categories that are consistent with guidelines established by the Canadian Institute for Health Information. These categories facilitate consistent, comparable reporting across jurisdictions.

Inpatient acute nursing care services represent AHS's largest program category and these costs are budgeted at $3,004 million or 22 percent of total expenses. This category is comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, pediatrics and mental health. These costs are budgeted to increase by 4.6 percent in 2013/14 to accommodate increased activity levels.

Emergency and other outpatient services are budgeted at $1,505 or 11 percent of total expenses. These costs are budgeted to increase by 6.4 percent in 2013/14 to accommodate increased activity levels.

Community-based care is budgeted at $1,199 million or 9 percent of total expenses. This category is comprised primarily of supportive living, palliative and hospice care, community programs, primary care networks and community mental health. These costs are budgeted to increase by 9.9 percent in 2013/14

as a result of our increased emphasis on building a strong integrated community and primary health care foundation.

Administration is budgeted at $481 million or 4 percent of total expenses and is comprised of human resources, finance, and general administration as well as a share of administration of contracted health service providers. General administration includes senior executive and many functions like communications, planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal. These costs are budgeted to increase by 0.4 percent.

AHS is committed to reducing administration and overhead costs in this category and other categories by a total of $35 million over the next 3 years.

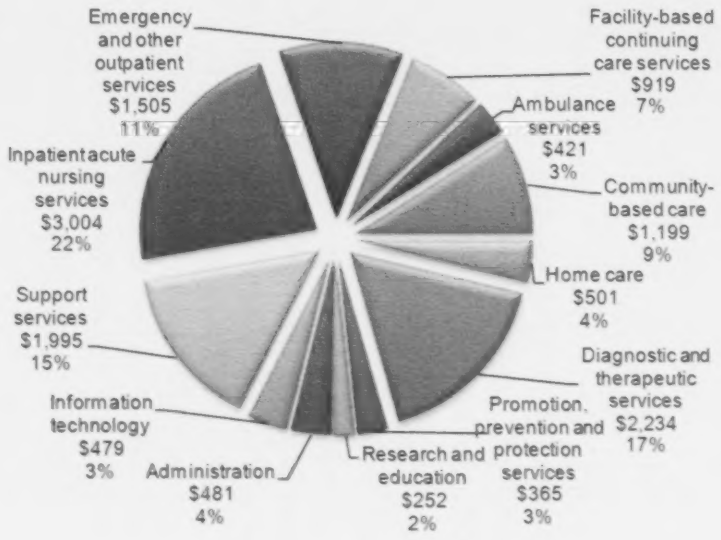
Incremental 2013/14 Expenses

AHS operating expenses are increasing by $618 million or 4.9 percent in 2013/14 and this increase consists of requirements to continue current operations, funding for strategic and new investments and expenses related to restricted grants.

Continuing current operations will require an additional $257 million including compensation and non-compensation requirements. The increase is comprised of funding to support known compensation increases under existing labour agreements, known benefit increases (such as the increase to employer contributions to the Local Authorities Pension Plan) and increases in contracts with partner providers.

$245 million of funding has been allocated to support strategic and new investments identified in the Health Plan. New investments include the Continuing Care Capacity Plan, investments in the

Figure 4: 2013/14 Expenses by Financial Directive


Emergency and other outpatient services $1,505 11%
Facility-based continuing care services $919 7%
Ambulance services $421 3%
Community-based care $1,199 9%
Home care $501 4%
Diagnostic and therapeutic services $2,234 17%
Promotion, prevention and protection services $365 3%
Research and education $252 2%
Administration $481 4%
Information technology $479 3%
Support services $1,995 15%
Inpatient acute nursing services $3,004 22%

Strategic Clinic Networks, additional neonatal intensive care spaces at the Alberta Children's Hospital, the opening of the Red Deer Cancer facility and the relocation of air ambulance services from the Edmonton City Centre Airport to the Edmonton International Airport.

In order to fund new investments, all AHS programs will achieve savings in 2013/14. $209 million of expense savings and $11 million of additional revenue initiatives will be achieved and re-allocated to support the strategic investments. Savings initiatives include productivity and efficiency gains including

staff scheduling transformation, optimizing facilities and services, and new revenue opportunities.

$325 million of the total increase in 2013/14 expenses is for new and increasing restricted grants. $126 million of the increase is to support the South Health Campus and Kaye Edmonton Clinic (total annual funding of $393 million). $44 million is to support increases to specialty drugs, and $82 million is for physician related agreements (i.e. Academic Alternate Relationship Plans, Alternative Relationship Plans, Medical Residents). An additional $22 million is also required to support the Primary Care Networks. All restricted expenses are offset by revenues.

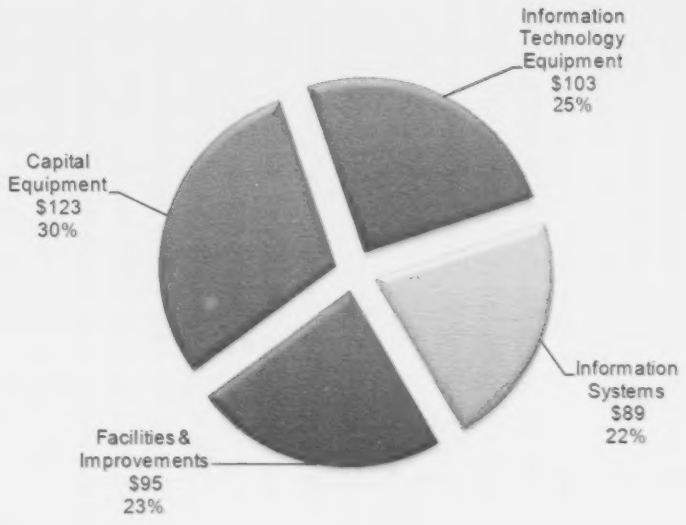
Capital Assets

The capital budget for 2013/14 will be $410 million. This includes $202 million of tangible capital assets purchased with internal funds and $208 million with external funds.

Facilities, medical equipment and information technology are integral to AHS's clinical and business processes and are key enablers for transformation. Key investments in 2013/14 include:

- Facility enhancements and upgrades to maintain clean and healthy environments where infection control standards are met and facilities are maintained to provide a comfortable atmosphere;
- Equipment purchases and replacements in areas such as diagnostic imaging, cancer care, and ambulances;
- Information technology investments including the provincial Clinical Information System, wireless access coverage and upgrades in core platforms, and networks to enhance sustainability and reliability.

Figure 4: 2013/14 Expenses by Financial Directive


Information Technology Equipment $103 25%
Capital Equipment $123 30%
Information Systems $89 22%
Facilities & Improvements $95 23%

Outlook / Sustainability

AHS's Multi-Year Outlook and Health Plan are based on an in-depth understanding of the drivers of health care expenditures and strategies and the need to manage these cost drivers to achieve sustainability while moving forward on the strategic directions.

Cost drivers are grouped into four categories:

Inputs and cost of inputs:

- Alberta's Registered Nurse (RN) and Licensed Practical Nurse (LPN) salaries are the second highest in the country;
- Alberta has the largest volume of physicians per person, as well as a high volume of physician services per person. Alberta has the highest cost per physician claim and the highest total billings per physician;
- Alberta has more acute care beds per adjusted capita than the national level;
- Consistent with the relatively large volume of acute care beds and physicians per capita, Alberta spends more per adjusted capita than the national average for hospitals ($431.73 more) and physicians ($64.14 more) as well as other institutions, other professionals, drugs, capital, public health, and other health spending (in constant dollars);
- On the other hand, Alberta has relatively lower long-term care bed capacity and a relatively lower ratio of long-term care to acute care beds.

Inputs / unit of service:

- Alberta's cost per weighted case is the second highest in the country. This is likely due to higher salary costs;
- On the positive side, AHS's administration expenditure and a percentage of total expenditures is the lowest in the country.

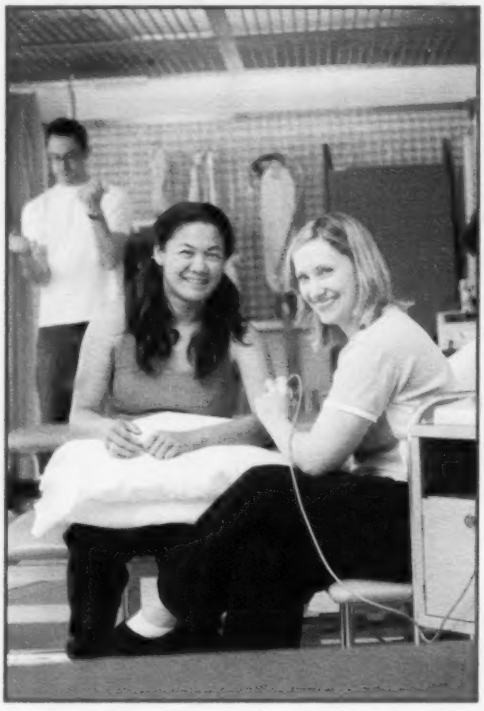
Volume of services used:

- Consistent with the higher volume of acute care beds per capita, Alberta has more acute hospital stays than the national average (17.6 percent higher per adjusted capita than the national rate);
- Alberta has more emergency department (ED) visits per adjusted capita than Ontario (the only other province reporting this data for all sites). Alberta also has a higher proportion of ED cases in the lowest acuity levels (Canadian Triage and Scale levels 4 and 5) as well as lower average resource intensity weight and shorter average visit time.

Type of services used:

- Providing services in higher-cost settings also contributes to higher expenditures;
- Alberta's inpatient average length of stay (ALOS) is close to the national average, but there are notable differences between typical cases where Alberta's ALOS is shorter than the national average and atypical cases are significantly longer than the national average;
- Alberta has the longest average acute care length of stay for clients discharged to continuing care (consistent with the relatively fewer long-term care beds mentioned above).

Based on the above, the Health Plan and 2013/14 Budget are aligned with the following operational tactics:



Patient Care:

- Manage growth of acute care beds provincially;
- Support growth in highly specialized provincial services where identified need exists, to improve outcomes and value;
- Align care to ensure the appropriate type of care, provider, and setting across communities.

Our Staff / Physicians and Volunteers:

- Implement a hiring "chill" so that the absolute number of staff does not increase;
- Minimize job loss for front-line staff and seek to redeploy displaced staff where possible;
- Reduce the utilization of contracted resources for non-clinical activities.

Overall:

- Continue to implement activity based funding where appropriate;
- Hold activity to 12/13 levels unless specific approvals are granted;
- Reduce administrative costs by 10 percent;
- Redeploy resources from initiatives that are not aligned with strategic directions.

Key Risks

AHS actively monitors and manages risks that may impact the achievement of its strategic directions. The Enterprise Risk Management (ERM) priority risk areas for AHS are:

Sustainable Workforce

Financial Sustainability

Quality, Safety and Patient Flow

Infrastructure – Information Technology

Informed Decisions

Health and Safety

Risk mitigation plans are being developed for each priority risk area to guide risk management activities. The plans will:

- Identify key root causes (contributing factors);
- Create short and long term mitigation strategies;
- Identify key risk indicators and/or performance measures (data driven process);
- Identify risk tolerance and risk targets for the next 3 years.

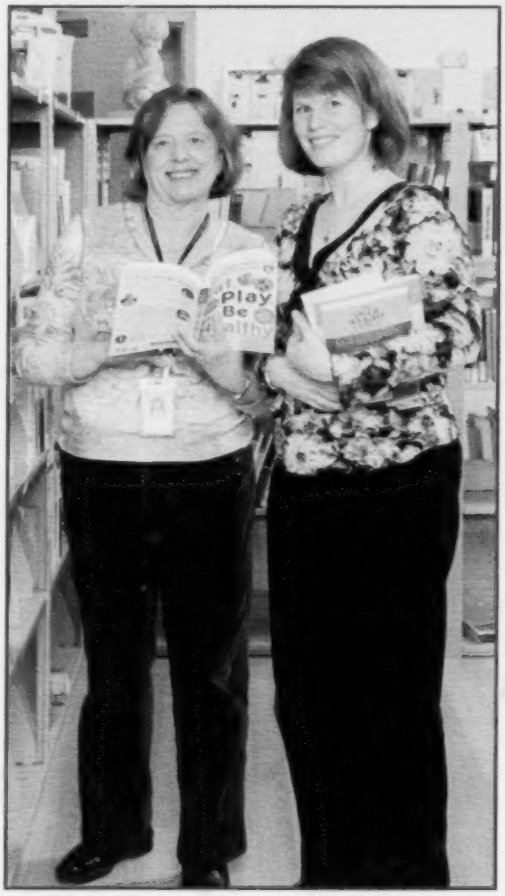
In addition to the priority risk areas, there are risks specific to the budget. AHS will actively manage these risks and implement mitigation strategies. These risks include:

Compensation: Salaries and benefits account for a significant proportion of AHS's expenses. The collective agreement with the United Nurses of Alberta expired on March 31, 2013. Other collective agreements will expire over the next 2 years and will impact future year requirements.

Demand growth: Increasing demand for health care services may result in increased expenses. AHS is planning initiatives to ensure appropriate utilization of health care services in the right setting and to ensure quality and patient safety are maintained.

Cost inflation: Expenses may be higher than anticipated due to increased cost inflation in areas such as drugs, medical and surgical supplies and contracted services. AHS is working on initiatives to mitigate cost increases, including contract reviews and bulk purchasing opportunities, along with work by Strategic Clinical Networks to promote evidence informed standards.

Savings: The balanced operating position budgeted for 2013/14 is predicated on the achievement of savings. A number of these savings initiatives are of medium to high risk. To ensure savings are achieved, initiatives will be closely monitored and mitigation strategies are being considered. The savings initiatives have a financial benefit and also create additional human resource capacity to support priority and transformational initiatives.



Transition to Public Sector Accounting Standards

The budget schedules reflect changes required as a result of the adoption of the Canadian Institute of Chartered Accountants (CICA) Public Sector Accounting Standards (PSAS). The key measurement changes include recording accumulated non-vesting sick leave obligation and consolidating the controlled foundations. In addition to a number of reclassifications in revenue and in assets and liabilities, a key presentation change is the reporting of AHS's accumulated surplus. Under PSAS, the accumulated surplus includes:

- Unrestricted net assets – previously referred to as accumulated surplus (i.e., portion of net assets that is available for future use);
- Reserves for future purposes – the Board has approved the creation of reserves to support South Health Campus, cancer research, parkade infrastructure, CCGI sites, specific local initiatives, and retail food services infrastructure; and
- Net assets invested in tangible capital assets.

An adjusted 2012/13 Budget is included for comparison purposes. Note 1 to the following consolidated budgeted financial statements describe the adjustments and Note 3 describes the accumulated surplus.

MULTI YEAR OUTLOOK
YEARS ENDED MARCH 31

	2013 Budget (Note 1) (Schedule 2)	2014 Budget	2015 Outlook	2016 Outlook
Revenue:				
Alberta Health transfers				
Base operating grants [3]	$ 10,212	$ 10,521	$ 10,838	$ 11,449
Other operating grants	1,164	1,446	1,584	1,328
Capital grants	96	98	101	103
Other government transfers	344	389	405	431
Fees and charges	439	456	461	461
Ancillary operations	127	129	135	135
Donations, fundraising and non-government grants	129	131	140	151
Investment and other income	218	185	189	192
TOTAL REVENUE	12,729	13,355	13,853	14,250
Expenses:				
Inpatient acute nursing services	2,872	3,004	3,087	3,163
Emergency and other outpatient services	1,414	1,505	1,563	1,616
Facility-based continuing care services	880	919	969	1,005
Ambulance services	404	421	430	433
Community-based care	1,091	1,199	1,307	1,408
Home care	480	501	513	518
Diagnostic and therapeutic services	2,146	2,234	2,294	2,331
Promotion, prevention and protection services	359	365	373	378
Research and education	226	252	272	292
Administration	479	481	487	491
Information technology	464	479	489	495
Support services	1,922	1,995	2,069	2,120
TOTAL EXPENSES	12,737	13,355	13,853	14,250
OPERATING SURPLUS (DEFICIT)	$ (8)	$ -	$ -	$ -

The accompanying notes and schedules are part of these consolidated budgeted financial statements.

[3] The new facilities grant of $393 million is reported under other operating grants for 2013/14 and 2014/15. AHS has assumed that the funding will be added to the base operating grant in 2015/16. This change has no impact to overall funding.

CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED MARCH 31

	2014 Budget	2013 Budget (Note 1) (Schedule 2)	Change	% Change
Revenue:				
Alberta Health transfers				
Base operating grants	$ 10,521	$ 10,212	$ 309	3.0%
Other operating grants	1,446	1,164	282	24.2%
Capital grants	98	96	2	2.1%
Other government transfers	389	344	45	13.1%
Fees and charges	456	439	17	3.9%
Ancillary operations	129	127	2	1.6%
Donations, fundraising and non-government grants	131	129	2	1.6%
Investment and other income	185	218	(33)	(15.1%)
TOTAL REVENUE	13,355	12,729	626	4.9%
Expenses:				
Inpatient acute nursing services	3,004	2,872	132	4.6%
Emergency and other outpatient services	1,505	1,414	91	6.4%
Facility-based continuing care services	919	880	39	4.4%
Ambulance services	421	404	17	4.2%
Community-based care	1,199	1,091	108	9.9%
Home care	501	480	21	4.4%
Diagnostic and therapeutic services	2,234	2,146	88	4.1%
Promotion, prevention and protection services	365	359	6	1.7%
Research and education	252	226	26	11.5%
Administration	481	479	2	0.4%
Information technology	479	464	15	3.2%
Support services	1,995	1,922	73	3.8%
TOTAL EXPENSES	13,355	12,737	618	4.9%
OPERATING SURPLUS (DEFICIT)	-	(8)	8	100%
Accumulated surplus at the beginning of the year [4]	1,011	988	23	2.3%
Accumulated surplus at the end of the year (Note 3)	$ 1,011	$ 980	$ 31	3.2%

The accompanying notes and schedules are part of these consolidated budgeted financial statements.

[4] The 2013/14 accumulated surplus at the beginning of the year has been prepared using the Quarter 3 forecast adjusted for additional PSAS changes instead of the budgeted 2012/13 accumulated surplus at the end of the year, resulting in a more accurate 2013/14 budgeted accumulated surplus.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
AS AT MARCH 31

	2014 Budget	2013 Budget (Note 1) (Schedule 2)	Change	% Change
Assets:				
Cash and cash equivalents	$ 885	$ 833	$ 52	6.2%
Portfolio investments	1,275	1,325	(50)	(3.8%)
Accounts receivable	400	368	32	8.7%
Other assets	37	38	(1)	(2.6%)
Tangible capital assets	7,192	7,525	(333)	(4.4%)
Inventories for consumption	110	105	5	4.8%
Prepaid expenses	75	59	16	27.1%
TOTAL ASSETS	$ 9,974	$ 10,253	$ (279)	(2.7%)
Liabilities:				
Accounts payable and accrued liabilities	$ 1,082	$ 1,416	$ (334)	(23.6%)
Employee future benefits	574	566	8	1.4%
Deferred revenue	6,887	6,862	25	0.4%
Debt	346	364	(18)	(4.9%)
TOTAL LIABILITIES	$ 8,889	$ 9,208	$ (319)	(3.5%)
Net Assets:				
Accumulated surplus (Note 3)	$ 1,011	$ 980	$ 31	3.2%
Endowments	63	63	-	-%
Accumulated remeasurement gains and losses	11	2	9	450.0%
TOTAL NET ASSETS	$ 1,085	$ 1,045	$ 40	3.8%

The accompanying notes and schedules are part of these consolidated budgeted financial statements.

CONSOLIDATED STATEMENTS OF ACCUMULATED REMEASUREMENT GAINS AND LOSSES
YEARS ENDED MARCH 31

	2014 Budget	2013 Budget (Note 1)	Change	% Change
Balance at the beginning of the year	$ 2	$ -	$ 2	-%
Adjustment on adoption of the financial instruments standard	-	18	(18)	(100.0%)
Unrealized gains (losses) attributable to portfolio investments transferred to endowments	-	(5)	5	100.0%
Unrealized gains (losses) attributable to portfolio investments transferred to deferred revenue	-	(9)	9	100.0%
Unrealized gains (losses) attributable to portfolio investments	6	(6)	12	100.0%
Realized gains (losses) reclassified to the Consolidated Statement of Operations attributable to portfolio investments	3	4	(1)	(25.0%)
Balance at the end of year	$ 11	$ 2	$ 9	450.0%

The accompanying notes and schedules are part of these consolidated budgeted financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED MARCH 31

	2014 Budget [5]	2013 Budget (Note 1) (Schedule 2)
Operating transactions:		
Operating surplus (deficit)	$ -	$ (8)
Non-cash transactions:		
Amortization expense, loss on disposal and write-down	560	521
Recognition of expended deferred capital revenue	(390)	(374)
In-kind transfer of land recognized as revenue	-	-
Bond amortization	12	13
Decrease (increase) in:		
Accounts receivable related to operating transactions	(32)	(20)
Inventories for consumption	(5)	(8)
Other assets	1	18
Prepaid expenses	(16)	-
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	37	55
Employee future benefits	8	52
Deferred revenue related to operating transactions	37	(79)
Cash provided by (applied to) operating transactions	212	170
Capital transactions:		
Acquisition of tangible capital assets	(410)	(556)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	13	13
Cash provided by (applied to) capital transactions	(397)	(543)
Investing transactions:		
Purchase of portfolio investments	(2,339)	(4,310)
Proceeds on sale of portfolio investments	2,402	4,522)
Cash provided by (applied to) investing transactions	63	212
Financing transactions:		
Deferred capital revenue received	144	163
Deferred capital revenue returned	(2)	(107)
Deferred capital revenue payable transferred from (to) accounts payable	-	107
Proceeds from debt	-	32
Principal payments on debt	(18)	(38)
Cash provided by (applied to) financing transactions	124	157
Net increase (decrease) in cash and cash equivalents	2	(4)
Cash and cash equivalents, beginning of year [5]	883	837
Cash and cash equivalents, end of year	$ 885	$ 833

The accompanying notes and schedules are part of these consolidated budgeted financial statements.

[5] The 2013/14 cash flow has been prepared using the change between the March 31, 2014 budgeted statement of financial position and the Quarter 3 forecasted March 31, 2013 statement of financial position instead of the budgeted March 31, 2013 statement of financial position. This results in a more accurate 2013/14 budgeted cash flow statement.

NOTES TO THE CONSOLIDATED BUDGETED FINANCIAL STATEMENTS
MARCH 31, 2014

Note 1 Reported Budget

The AHS Health Plan and Business Plan 2012-15, which included the 2012/13 annual budget, was approved by the Board on May 3, 2012. The budget details were presented in accordance with Canadian Generally Accepted Accounting Principles (CGAAP) but included a reconciliation for PSAS transition adjustments.

The 2012/13 budget was approved by the Board in advance of the implementation of a new AHS budgeting and planning system. This budget was prepared at a financial statement level. At the end of the summer, AHS implemented the new budget system and used it to rebuild the budget at the cost centre level using the same assumptions as the original budget (e.g., inflation, savings targets, and Health Quality Council and other investments). The revised budget was used for management accountability reporting in 2012/13. The original and revised budgets have the same total revenues and expenses, however because the original budget was prepared at a high level and the revised budget was built at a detailed level, the original budget is not the same as the revised budget for every category of revenues and expenses. These resulting differences referred to as "budget system reclassifications" cannot be attributed to any change in assumption, program or specific initiative.

The 2012/13 budget in this document reflects the internal budget used for management reporting. Schedule 2 demonstrates how the Board approved budget has been transitioned to reflect these changes.

Note 2 Amortization, Disposals and Write-Downs

	2014 Budget	2013 Budget (Note 1)	Change	% Change
Internally funded equipment	$ 75	$ 52	$ 23	44.2%
Internally funded information systems	67	67	-	-%
Internally funded facilities and improvements	28	28	-	-%
Externally funded equipment	122	106	16	15.1%
Externally funded information systems	48	37	11	29.7%
Externally funded facilities and improvements	220	231	(11)	(4.8%)
Loss on disposal of capital assets	-	-	-	-%
	$ 560	$ 521	$ 39	7.5%

Note 3 Accumulated Surplus

	Unrestricted net assets	Reserves for future purposes	Operating net assets	Net assets invested in tangible capital assets	Accumulated surplus
Balance as at April 1, 2012	$ (8)	$ 123	$ 115	$ 873	$ 988
Operating surplus (deficit)	(8)	-	(8)	-	(8)
Tangible capital assets purchased with internal funds	(204)	-	(204)	204	-
Amortization of internally funded tangible capital assets	147	-	147	(147)	-
Repayment of debt used to fund tangible capital assets	(12)	-	(12)	12	-
Transfer of reserves for future purposes	20	(20)	-	-	-
Balance as at March 31, 2013	$ (65)	$ 103	$ 38	$ 942	$ 980
Balance as at April 1, 2013 [6]	$ (2)	$ 103	$ 101	$ 910	$ 1,011
Operating surplus (deficit)	-	-	-	-	-
Tangible capital assets purchased with internal funds	(202)	-	(202)	202	-
Amortization of internally funded tangible capital assets	170	-	170	(170)	-
Repayment of debt used to fund tangible capital assets	(15)	-	(15)	15	-
Transfer of reserves for future purposes	3	(3)	-	-	-
Balance as at March 31, 2014	$ (46)	$ 100	$ 54	$ 957	$ 1,011

[6] The balance as at April 1, 2013 has been prepared using the Quarter 3 forecast adjusted for additional PSAS changes instead of the budgeted balance as at March 31, 2012, resulting in a more accurate 2013/14 budgeted accumulated surplus.

(a) **Reserves**

The Board has approved the budgeted restriction of net assets for future purposes as follows:

	March 31, 2014	March 31, 2013
	Budget	Budget
South Health Campus [(i)]	$ -	$ 25
Cancer research reserve [(ii)]	27	27
Parkade infrastructure reserve [(iii)]	47	25
CCGI sites reserve [(iv)]	14	14
Specific local initiatives reserve [(v)]	12	12
Retail food services infrastructure reserve [(vi)]	-	-
Reserves for future purposes	100	103
Invested in tangible capital assets [(vii)]	957	942
Total reserves	$ 1,057	$ 1,045

(i) The AHS Board has approved the restriction of operating net assets to assist with funding start up costs for South Health Campus in Calgary.

(ii) The AHS Board has approved the restriction of operating net assets to fund cancer research.

(iii) The AHS Board has approved the restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades, and construction.

(iv) The AHS Board has approved the restriction of operating net assets for operating and capital purposes at CCGI sites.

(v) The AHS Board has approved the restriction of operating net assets for specific initiatives as a result of local fundraising.

(vi) The AHS Board is expected to approve the restriction of retain food services surplus to assist with future upgrades, maintenance, equipment, and construction costs for retain food service operations.

(vii) The AHS Board has approved the restriction of net assets equal to the net book value of internally funded tangible capital assets as these net assets are not available for any other purpose.

(b) Operating net assets

Operating net assets represent accumulated surplus available for use and therefore exclude amounts already invested in tangible assets. Unrestricted net assets exclude all reserves and represent accumulated surplus that has not been internally restricted through board approval for a specific purpose.

If AHS reports an operating net asset deficiency at March 31, 2013 then Alberta Regulation 15/95 of the *Regional Health Authorities Act* (Alberta) requires AHS to submit a deficit elimination plan

SCHEDULE 1 – CONSOLIDATED SCHEDULES OF EXPENSES BY OBJECT
YEARS ENDED MARCH 31

	2014 Budget	2013 Budget (Note 1) (Schedule 2)	Change	% Change
Salaries and benefits	$ 7,101	$ 6,844	$ 257	3.8%
Contracts with health service providers	2,314	2,231	83	3.7%
Contracts under the Health Care Protection Act	18	19	(1)	(5.3%)
Drugs and gases	412	351	61	17.4%
Medical and surgical supplies	385	375	10	2.7%
Other contracted services	1,212	1,119	93	8.3%
Other	1,353	1,277	76	6.0%
Amortization, disposals and write-downs (Note 2)	560	521	39	7.5%
	$ 13,355	$ 12,737	$ 618	4.9%

SCHEDULE 2 – CONSOLIDATED SCHEDULE OF BUDGET
YEAR ENDED MARCH 31, 2013

a) Reconciliation of the Consolidated Statement of Operations

	Board Approved Budget	Transition to PSAS (Note 1)	Budget System Reclassifications (Note 1)	Reported Budget
Revenue:				
Alberta Health contributions/Alberta Health transfers				
Unrestricted ongoing/Base operating grants	$ 10,212	$ -	$ -	$ 10,212
Restricted/Other operating grants	1,164	-	-	1,164
Capital grants	-	96	-	96
Other government contributions/ Other government transfers	119	243	(18)	344
Fees and charges	439	-	-	439
Ancillary operations	127	-	-	127
Donations/Donations, fundraising and non-government grants	27	102	-	129
Investment and other income	222	(22)	18	218
Amortized external capital contributions *	374	(374)	-	-
TOTAL REVENUE	12,684	45	-	12,729
Expenses:				
Inpatient acute nursing services	2,918	5	(51)	2,872
Emergency and other outpatient services	1,356	-	58	1,414
Facility-based continuing care services	971	-	(91)	880
Ambulance services	415	-	(11)	404
Community-based care	1,054	-	37	1,091
Home care	496	-	(16)	480
Diagnostic and therapeutic services	2,143	5	(2)	2,146
Promotion, prevention and protection services	368	-	(9)	359
Research and education	234	15	(23)	226
Administration	397	-	82	479
Information technology	480	-	(16)	464
Support services	1,593	287	42	1,922
Amortization of facilities and improvements*	259	(259)	-	-
TOTAL EXPENSES	12,684	53	-	12,737
OPERATING SURPLUS (DEFICIT)	$ -	$ (8)	$ -	$ (8)

*Line item not presented under PSAS
When a line item has changed names it is described as "2011-12 name / 2012-13 name".

SCHEDULE 2 – CONSOLIDATED SCHEDULE OF BUDGET AS AT MARCH 31, 2013 (CONTINUED)

b) Reconciliation of the Consolidated Statement of Financial Position

	Board Approved Budget	Transition to PSAS (Note 1)	Reported Budget
Assets:			
Cash and cash equivalents	$ 525	$ 308	$ 833
Non-current cash and investments*	429	(429)	-
Investments/Portfolio investments	987	338	1,325
Accounts receivable	238	130	368
Contributions receivable from AH*	78	(78)	-
Capital contributions receivable from AH*	-	-	-
Other assets	84	(46)	38
Capital assets/Tangible capital assets	7,525	-	7,525
Inventories/Inventories for consumption	105	-	105
Prepaid expenses	59	-	59
TOTAL ASSETS	$ 10,030	$ 223	$ 10,253
Liabilities:			
Accounts payable and accrued liabilities	$ 1,257	$ 159	$ 1,416
Employee future benefits	-	566	566
Accrued vacation pay*	475	(475)	-
Deferred revenue	391	6,471	6,862
Long-term debt/Debt	346	18	364
Current portion of long-term debt*	18	(18)	-
Deferred contributions current*	5	(5)	-
Deferred capital contributions*	133	(133)	-
Unamortized external capital contributions*	6,223	(6,223)	-
Other liabilities*	148	(148)	-
TOTAL LIABILITIES	$ 8,996	$ 212	$ 9,208
Net assets:			
Accumulated surplus (Note 3)	$ 1,021	$ (41)	$ 980
Endowments	10	53	63
Accumulated net unrealized gains (losses) on investments/Accumulated remeasurement gains and losses	3	(1)	2
TOTAL NET ASSETS	$ 1,034	$ 11	$ 1,045

*Line item not presented under PSAS
When a line item has changed names it is described as "2011-12 name / 2012-13 name".

SCHEDULE 2 – CONSOLIDATED SCHEDULE OF BUDGET YEAR ENDED MARCH 31, 2013 (CONTINUED)

c) Reconciliation of the Consolidated Statement of Cash Flows

	Board Approved Budget	Transition to PSAS (Note 1)	Reported Budget
Operating transactions:			
Operating surplus (deficit)	$ -	$ (8)	$ (8)
Non-cash transactions:			
Amortization expense, loss on disposal and write-down	521	-	521
Amortization of external capital contributions/ Recognition of expended deferred capital revenue	(374)	-	(374)
Bond amortization	-	13	13
Decrease (increase) in:			
Accounts receivable relating to operating transactions	-	(20)	(20)
Inventories for consumption	-	(8)	(8)
Other assets	-	18	18
Prepaid expenses	-	-	-
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	-	55	55
Employee future benefits	-	52	52
Deferred revenue related to operating transactions	-	(79)	(79)
Other*	(8)	8	-
Changes in non-cash working capital*	14	(14)	-
Cash provided by (applied to) operating transactions	153	17	170
Capital transactions:			
Acquisition of tangible capital assets	(556)	-	(556)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	-	13	13
Changes in non-cash working capital*	13	(13)	-
Cash (applied to) capital transactions	(543)	-	(543)
Investing transactions:			
Purchase of portfolio investments	(4,310)	-	(4,310)
Proceeds on sale of portfolio investments	4,535	(13)	4,522
Allocation from (to) non-current cash and investments*	(269)	269	-
Cash provided by (applied to) investing transactions	(44)	256	212
Financing transactions:			
Capital contributions received/ Deferred capital revenue received	163	-	163
Capital contributions returns/ Deferred capital revenue returned	(107)	-	(107)
Capital contributions payable transferred to accounts payable/ Deferred capital revenue payable transferred to accounts payable	107	-	107
Proceeds from debt	32	-	32
Principal payments on debt	(38)	-	(38)
Cash provided by financing transactions	157	-	157
Net increase (decrease) in cash and cash equivalents	(277)	273	(4)
Cash and cash equivalents, beginning of year	1,789	(952)	837
Cash and cash equivalents, end of year	$ 1,512	$ (679)	$ 833

*Line item not presented under PSAS
When a line item has changed names it is described as "2011-12 name / 2012-13 name".

SCHEDULE 2 – CONSOLIDATED SCHEDULE OF BUDGET
YEAR ENDED MARCH 31, 2013 (CONTINUED)

d) Reconciliation of the Consolidated Schedule of Expense by Object

	Board Approved Budget	Transition to PSAS (Note 1)	Budget System Reclassifications (Note 1)	Reported Budget
Salaries and benefits	$ 6,838	$ 13	$ (7)	$ 6,844
Contracts with health service providers	2,265	-	(34)	2,231
Contracts under the Health Care Protection Act	21	-	(2)	19
Drugs and gases	386	-	(35)	351
Medical and surgical supplies	354	-	21	375
Other contracted services	1,148	-	(29)	1,119
Other	1,151	40	86	1,277
Amortization, disposals and write-downs (Note 2)	521	-	-	521
	$ 12,684	$ 53	$ -	$ 12,737

ALBERTA HEALTH SERVICES

Health Plan
and
Business Plan
2013-2016

Better Quality, Better Outcomes,
Better Value

Alberta Health Services